

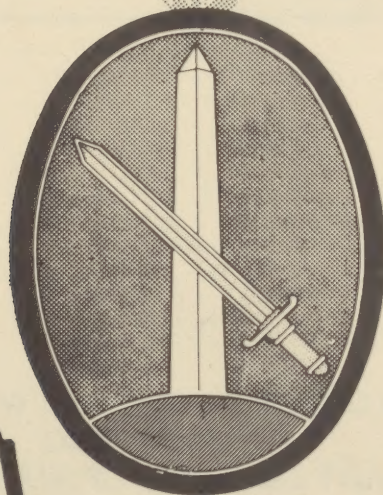
2
2
M6-m
V13
VOLUME 4

REPORT NO.7

(DOCUMENT SECTION)
RESTRICTED

MONTHLY HEALTH REPORT

Military District of Washington



RESTRICTED

JULY 1951

ARMY
MEDICAL
AUG 16 1951

LIBRARY



THIS DOCUMENT CONTAINS INFORMATION
AFFECTING THE NATIONAL DEFENSE OF
THE UNITED STATES WITHIN THE MEANING
OF THE ESPIONAGE LAWS, TITLE 18, U.S.C.,
SECTIONS 793 AND 794. THE TRANSMISSION
OR THE REVELATION OF ITS CONTENTS IN
ANY MANNER TO AN UNAUTHORIZED PER-
SON IS PROHIBITED BY LAW. (SEE AR 380-5)

MAJOR GENERAL THOMAS W. HERREN
COMMANDING
MILITARY DISTRICT OF WASHINGTON
Room 1543, Building T-7, Gravelly Point
Washington 25, D. C.



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

Contributions, as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

ROBERT E. BITNER
Colonel, MC
Surgeon

CONTENTS

	PAGE
APPOINTMENT OF NEW SURGEON GENERAL OF THE ARMY	
General Armstrong Appointed New Army Surgeon General.	1
ADMINISTRATIVE SERVICE	
Career Management for Army Medical Officers	2
Protection of Moral Standards	5
Table -- Hospital Mess Administration	20
Table -- Outpatient Service	20
CIVILIAN EMPLOYEES' HEALTH SERVICE PROGRAM	
Health Maintenance of Key Personnel	21
DENTAL SERVICE	
Table -- Dental Service	20
NURSING SERVICE	
Campaign for Courtesy	12
PROFESSIONAL SERVICE	
Achievements in Military Medicine	8
Effect of the National Emergency on the Eligibility Requirements for Board Certification	9
PREVENTIVE MEDICINE	
General Comment	14
Communicable Disease	14
Table -- General Data	15
Table -- Admissions, Specified Diseases	15
Venereal Disease	16
Table -- New Venereal Disease Cases	16
Chart -- Admission Rates of Common Respirary Disease and Injury	17
Chart -- Venereal Disease Admission Rates by Month	17
Chart -- Venereal Disease White Rates	18
Chart -- Venereal Disease Negro Rates	18
Chart -- Venereal Disease Total Rates	18
Table -- Venereal Disease Rates for U.S.	19
Table -- Consolidated Venereal Disease Statistical Report	19
VETERINARY SERVICE	
Diseases of Animals Important to Man in Time of War	6
Table -- Veterinary Service	20



NOTE: Captain Robert W. Holbrook, MSC, Executive Officer to the Surgeon, MDW, is currently attending the University of Massachusetts on Temporary Duty taking Advanced Training in Sanitary Engineering. Capt Holbrook has conducted intensive research in paper products as an aid to the development of environmental health standards.



NEW SURGEON GENERAL OF THE ARMY

Major General George E. Armstrong (center) is sworn in as Surgeon General of the Army, by Major General William E. Bergin, The Adjutant General (left), during a ceremony in the office of General J. Lawton Collins, Chief of Staff, U. S. Army (right).

APPOINTMENT OF NEW SURGEON GENERAL OF THE ARMY

GENERAL ARMSTRONG APPOINTED NEW ARMY SURGEON GENERAL

The Senate has confirmed the Presidential nomination of Major General George E. Armstrong to be Surgeon General of the Army for a statutory four year term beginning 1 June 1951.

General Armstrong succeeds Major General R. W. Bliss, under whom he has served as Deputy Surgeon General for the past four years.

General Armstrong was born on 4 August 1900, near Springville, Lawrence County, Indiana. He received an A. B. degree in 1922 and an M. D. degree in 1925 from the University of Indiana. After serving in the SATC in 1918, he enlisted as a private in the National Guard of Indiana in March 1923 and was honorably discharged as a Technical Sergeant in 1925 to accept a commission as a First Lieutenant in the Army Reserve Corps. Following internship at Letterman General Hospital, San Francisco, California, he was commissioned a First Lieutenant in the Regular Army Medical Corps on 9 July 1926.

His first tour of duty was attendance at the Medical Field Service School Carlisle Barracks, Pennsylvania, from which he was graduated with honors. Subsequent schools included graduation from the Army Medical School, Washington, D. C., with honors; Advanced Course, Medical Field Service School and the Command and General Staff School, Fort Leavenworth, Kansas.

He has served at various posts since his entry on active duty including Walter Reed General Hospital, Washington, D.C.; Fort Benning, Georgia; Tientsin, China; Fort Stotsenberg, Philippine Islands.

During World War II, he served as Assistant Theater Surgeon, China-Burma-India, 1943-1944; followed by two years as Surgeon of the China Theater. He returned to the United States in July 1946 after three years of overseas service to serve as Chief of Personnel, Surgeon General's Office, Washington, D. C. In June 1947, he was appointed Deputy Surgeon General.

He is a Fellow of the American College of Surgeons and the American Medical Association; a member of the Association of Military Surgeons of the United States Masonic Blue Lodge; Scottish Rite and Shrine; Phi Kappa Psi; Alpha Omega Alpha; Phi Rho Sigma; and Scabbard and Blade Fraternities. He serves as a member of the House of Delegates of the American Medical Association; liaison member of the Executive Council of the Association of American Medical Colleges; and is a member of the Board of Directors of the American Bureau for Medical Aid to China.

His decorations include the Legion of Merit, the Army Commendation Ribbon, World War I Victory Medal, The American Defense Service Medal, the Asiatic-Pacific Campaign Medal with three bronze stars, World War II Victory Ribbon, Chinese Cloud and Banner, Chinese Legion of Honor, and the Order of the Crown of Italy (Commandership).

ADMINISTRATIVE SERVICE

CAREER MANAGEMENT FOR ARMY MEDICAL OFFICERS

It seemed appropriate today to talk about our Career Management program for Army Medical officers. Lt. Colonel Fred Fielding, Personnel Division of my office, has a paper on this subject which is soon to be published in the Armed Forces Medical Journal as well as in an early edition of the civilian periodical MD. The civilian interest in this subject speaks well of what we believe is our successful development and implementation of a very vital program. I have extracted and interpreted essential portions of Colonel Fielding's article to present to you.

In 1948 the Army published its personnel policy. Among other things the policy stated that the individual is the most important single asset in any Army. Implementation of this policy, in order that the Army could operate as an integrated team, seeks to improve daily working relationships by recognizing the dignity and importance of the individual. The Army Medical Service implements this policy by efficiently utilizing every man's abilities, providing opportunities for him to reach his highest possible proficiency, and planning for the future to effectively utilize all our available manpower.

Career planning for all medical personnel regardless of assignment area has been delegated to The Surgeon General.

Modern medicine has become so complex that specialization is required. To this end and within the limits of our specialist requirements, we expect to develop Medical Corps officers by training and experience to become thoroughly competent in their desired field of specialization. Such officers will be continued in their specialty field as long as they continue to demonstrate their professional competence. Ordinarily they will not be shifted from their chosen field unless necessity so dictates.

In order to insure that career assignments receive proper consideration, controls have been established to enable field commanders to implement Army personnel policies. One of these controls is the inclusion of the professional classification in the orders when an officer changes station.

We have three principal groups of medical officers for the purposes of career management. These are professional specialists, medical commanders and medical staff officers. They are of equal importance in the efficient functioning of the Medical Corps. There is no difference in the promotion opportunity which is based upon service and past performance, between the officers of these three groups. Basically, the professional specialists group consists of highly trained officers in Medicine, Surgery, Neuropsychiatry, Pathology, Physical Medicine and Preventive Medicine. Within these broad fields are included officers who become more highly specialized in other specialties such as Dermatology, Anesthesia, Neurosurgery, Orthopedics, Radiology, etc. We expect that over half of the regular Medical Corps will be in these groups. For each of the specific broad professional fields, career patterns have been prepared, as well as for each of the subspecialties. These show a progression through types of assignment from the beginning of an individual's career until retirement at age sixty.

The second principal group is that of the medical commanders. This contains the named hospital and center commanders, T/O hospital unit commanders, medical depot commanders and the post surgeon - station hospital commanders. This group will contain about one-third of the regular Medical Corps. In analogy to civilian life, the highest levels of this group compare to general managers of the separate businesses of a corporation in that they control personnel and activities of the local unit.

The third principal group is that of the Medical Staff officers. They basically are the Army Staff Surgeons who may be specialized in field medical tactics, military medical training, medical personnel administration, medical supply management or medical strategic planning and operations. This career group contains the smallest and remaining portion of the Regular Medical Corps. Again in analogy to civilian life, the highest levels of this group compare to executive and vice president of a corporation in that their actions and decisions affect all of the members of the Medical Service.

For purposes of career management, there are three periods in which the career patterns are divided. These are the periods of basic training, specialization and definitive assignment. Until an officer reaches the permanent grade of Captain, which requires three years, he is considered in

ADMINISTRATIVE SERVICE

the basic training period. During this time, each officer will receive basic military medical training at our Medical Field Service School in San Antonio. The officer is under continuous study during this period, for probationary purposes as far as his Regular commission is concerned, and for his potentialities for professional clinical specialization as well as professional military medical specialization. He may be selected for residency training in a particular professional specialty. He may serve in general duty assignments in the United States or on foreign service with our various hospitals, dispensaries or field units. He may rotate through various professional assignments and learn the necessary administrative procedures concerned with patients in a military establishment. Throughout this entire period the officer becomes acquainted with the Army and Army Medical Service.

The period of specialization must consider the three principal career groups separately.

a. The Professional Specialists Group: When an officer is selected for residency training in a professional specialty, he is assigned such duty for a one year period. At the end of this time he may be selected for additional training with a view toward completion of his requirements necessary for certification by a specialty board. All residents in the same level within a particular specialty in all our teaching hospitals are considered on a competitive basis when reappointments are made for the next training year. Officers are assigned as assistant chiefs of sections or services or ward officers at various sized hospitals subsequent to or between their residency training periods. Each officer will attend the advanced branch course of field military medicine during the period of specialization. Ordinarily officers who are established in this career group will not have the opportunity for training in a higher level service school, such as the Command and Staff College, the Army War College, the Industrial College of the Armed Forces or the National War College.

b. Medical Commanders Group: Early in their careers some officers will show a particular aptitude for medical staff and command duties. For these officers, assignment planning at first will be in professional duties as a general medical officer. Dependent then upon an officer's capabilities and choice, he would be guided into two general channels - hospital administration or medical supply. Special details in his primary field of interest will follow with subsequent assignments as a student to civilian institutions - for courses in supply management, hospital administration, personnel management or public health. Selected individuals will attend the Command and General Staff College and the higher level service schools. During this period of specialization officers also will be assigned as assistant post surgeons and commanders of small hospital units.

c. Medical Staff Officers Group: Early in their careers a few officers will demonstrate potentialities as medical staff officers. This is an important quality to the medical service. As such, it must be recognized quickly and fostered even though the age and rank of the officer may preclude his independent assignment. During this period of basic training a majority of assignments for these officers will be in general medicine. Some officers may be assigned to Army Field Forces units and in the headquarters of the continental armies or overseas commands. Formal training for the staff group includes entire gamut of the service schools from the Command and General Staff to the National War College. This group, like the medical commanders, will also receive institutional training - Public Health, personnel management, radiation hazards, supply and hospital administration. Officers will also receive as part of their specialized training, assignments as advisors with military missions, as assistant military attaches, and as instructors in service schools.

In the definitive period of career management, officers will reach the peak of their career. For the professional clinical group this will mean assignments such as professional consultants to The Surgeon General or Army or overseas surgeons, and as chief of professional services in the named and teaching hospitals. For the medical commanders group assignments will include commanding officer of named hospitals and other major medical installations. For the medical staff officer assignments will include overseas and army surgeons.

The Surgeon General and his Deputy may be selected from among the outstanding officers in any one of the three groups.

Medical classification is an extremely important portion of our career management plan. Officers must be assigned to duties commensurate with their specialty training and degree of ability. The determination of these facts and classification activities for medical officers are centralized for the entire Army in the hands of The Surgeon General. For all other officers of the Army, classification is in the hands of local commanders and The Adjutant General.

ADMINISTRATIVE SERVICE

Medical classification is further refined by designating proficiency prefixes to classification numbers. This system again is only in use in the Medical Service. The prefixes are indicative of training ability in a specialty field. The prefixes A, B, C or D define levels of professional training and ability, which are summarized as follows:

Group A indicates outstanding qualifications in the specialty field.

Group B indicates certification by the American Specialty Board in the specific classification.

Group C indicates completion of the formal training required to meet the American Board requirements for certification.

Group D indicates the completion of twelve months approved residency or fellowship in the specialty.

A permanent medical officer classification board is established in my office. This board approves the award of all A and B classifications; approves all downgrading of proficiency prefixes and approves all changes in primary classification when an officer from the medical professional classifications is changed to staff or command and vice versa.

A medical officer career guidance ledger has been established and is maintained in the Career Guidance Branch of our Personnel Division. This ledger contains each Regular officer's name tabulated by his primary classification. Within each classification group, names are arranged chronologically by year when the officer reaches age sixty and are listed in one of five columns indicating the proficiency prefix of A, B, C, D or pending. Officers whose primary classification is that of other than a specialty field in which they are training and who have not yet obtained sufficient experience to receive a D prefix classification are carried in the pending columns. Prefixes are not utilized for officers in the Medical Command and Staff Field. These officers are carried in columns showing their permanent regular Army rank. The uses of this ledger are multiple. It insures a classification control through observations of an individual's progression upward through the proficiency classification as he qualifies in the Specialty. It is used to maintain an inventory of medical officers by classification. It is used to establish specialty training goals considering both the personnel inventory and requirements for specialists. It is used to check the assignments of chiefs of services in our principal hospitals in comparison to other qualified officers within the eligible classification group. Finally it is used to assist officers in deciding upon a career field when considering all personnel currently established within such a specialty field.

A Career Guidance record has been prepared for each regular officer within the Career Guidance Branch. The ledger contains all civilian and army professional and military training received, classification ratings and other pertinent information. The individual annual preference card is screened for information about location preferences and noted on his career record. Annual efficiency reports are also screened and considered prior to recommending an officer for further training as well as his next type duty assignment.

A chronological assignment card is also maintained which is used to control a normal rotation of permanent changes of station.

An individual professional progression pattern, appropriate to his career field, is furnished to each regular medical officer. His approximate position in the career channel on this pattern is indicated. At that time the officer is requested to confirm his desire for continued career in that particular field or to designate such alternate careers as he may wish to follow.

Through the operations of these personnel control instruments - the ledger, individual record, chronological card, classification board, medical classification system, individual professional progression patterns, and basic career assignment pattern- The Surgeon General can accomplish his responsibility for the career planning and guidance of Regular medical officers.

The career guidance principles of classification and, as far as possible, utilization within classification, are followed for Reserve medical officers on active duty. Since these officers are not careerists, they do not come within the other operations of the Career Guidance Branch.

ADMINISTRATIVE SERVICE

Through the operations of these mechanisms, and cooperation of field commanders, the personnel policy of the Department of Army "that the individual is the most important single asset in the Army" is implemented for the Medical Corps by assuring the most efficient utilization of every officer's abilities and providing opportunities for each man to attain the highest proficiency consistent with his capacity.

(The above article is an address by Maj Gen George E. Armstrong, The Surgeon General, U. S. Army before graduating Interns and Residents at Walter Reed Army Hospital, Washington, D.C.)

*

*

*

PROTECTION OF MORAL STANDARDS

Quoted for information is letter from Secretary of the Army, Frank Pace, Jr., dated 18 June 1951:

"1. It is my desire that you bring to the attention of all commanding officers in every echelon of your command, the following message from the Secretary of Defense:

'It is in the national interest that personnel serving in the Armed Forces be protected in the realization and development of moral, spiritual, and religious values consistent with the religious beliefs of the individuals concerned. To this end, it is the duty of commanding officers in every echelon to develop to the highest possible degree the conditions and influences calculated to promote the health, morals, and spiritual welfare of the personnel under their command.

This traditional responsibility of command is of especial importance at this time when the Congress is preparing to broaden the base of inductions into the armed forces. The people of this country have made it plain to both houses of Congress that they are determined that adequate effort be made both in military installations and in adjacent communities to safeguard the moral welfare of members of the armed forces. The Department of Defense, sharing this determination, directs that increased efforts of commanding officers be directed to insure the accomplishment of this objective.'

2. The magnificent efforts of our fighting forces in Korea have clearly accentuated the great value of preserving and strengthening those individual traits of character which contribute so much to the high type of leadership required to successfully conclude the Army's assigned missions. The Army has pledged itself to a consistent and concerted effort to develop sound character in its soldiers, as well as to train them in the science of warfare. Success in those objectives will be much more surely attained if commanders are successful in their efforts to develop sound and stable character. Those positive efforts must extend all the way from the highest echelon of command to the individual soldier. I believe it is of the utmost importance to the realization of the Army's mission that all officers and noncommissioned officers familiarize themselves with the Army Character Guidance Program as set forth in Army Regulation 15-120. The core of this program is the acceptance of responsibility, and the commander who recognizes this fact will have a genuine concern for the well-being of his troops.

3. To these ends, it is desired that there be renewed effort and emphasis at every level to instill these spiritual and moral qualities in all officers and enlisted personnel so as to make them more effective members of the Army and more substantial citizens."

(The above article is from SGO Circular No. 106, dated 29 June 1951)

VETERINARY SERVICE

DISEASES OF ANIMALS IMPORTANT TO MAN IN TIME OF WAR*

R. A. Kelser, D.V.M., Ph.D.

Professor of Bacteriology and Dean of Faculty,
School of Veterinary Medicine, University of Pennsylvania,
Philadelphia, Pa.

Of the various diseases and disease-conditions of lower animals which are of particular concern to man, a number of them take on added importance in time of war. For purpose of discussion they may be grouped in several categories. First, there are those diseases which are primarily maladies of the lower species but which are directly transmissible to man. Secondly, there are certain diseases and infections among the lower animal species which may or may not be ordinarily transmissible to man but which are of importance to him because he may contract disease or be made sick through food products of animal origin. In a third category may be placed certain animal diseases capable of transmission to man but not ordinarily common in the human family, and which undoubtedly would be considered by any enemy giving thought to the employment of biological warfare against us. Finally, there are those maladies of animals which, while not transmissible to man, are important to him because their presence among food producing animals constitutes a hazard to the food supply which is ordinarily critical in periods of war.

Of the diseases capable of being transmitted from animal to man there are some which occur during normal times but which may well become more common and much more important during war periods when usual control measures are capable of less effective enforcement or break down entirely. Further, there are those diseases which are not ordinarily present in the country in time of peace but may be introduced under conditions of war. Let me mention a few of these diseases of animals which may be transmitted to man.

I will refer first to rabies, not because it is the most important of these diseases, but because it represents, perhaps, the best known example of a disease of the lower species, particularly dogs, transmissible to man. As is well known, we have had rabies in the United States for many years. Even under the best of conditions the malady has not been controlled and prevented to the extent it could be were it possible to carry out the known measures necessary for the effective control and eradication of rabies. This has not been possible largely because of the reluctance of dog owners to subject their pets to the conditions and measures necessary. As a consequence, we have rabies with us in the United States. In time of war the movement of people from place to place and the congregating of military personnel in camps, posts and stations throughout the Armed Services afford opportunities for the greater spread of rabies than is the case under normal conditions. Further, if we assemble at different places many dogs for war service, as was done during World War II, a greater rabies hazard is presented if adequate precautions are not taken to prevent the introduction of the disease among the dogs. During the past war, for example, we had some 1500 to 2000 dogs in each of a number of War Dog Reception and Training Centers. If rabies had broken out at one or several of these centers it requires but little imagination to realize what possibly would have happened and the exposure likely to have been received by the individual soldiers used in connection with the training of these dogs.

Anthrax, primarily a disease of lower animals, sometimes involves the human family. In animals it is especially important in cattle and horses and to a lesser degree in sheep and hogs. The malady is transmitted to man either through direct contact with affected animals or indirectly through contact with animal products or by-products which may carry the spores of the anthrax organism. Some of you will recall the difficulty which was experienced with anthrax during World War I. In that connection shaving brushes proved to be the agent which carried the anthrax infection. The brushes were made from horse hair which had come from China and Siberia where anthrax was very prevalent. The usual precautions in handling, cleaning, and disinfecting the hair were neglected under the conditions of war with the result that trouble from anthrax in man arose. In the United States there were approximately 150 cases of anthrax, with 22 deaths, associated with shaving brushes. A similar type of experience was had in England.

Glanders, a serious malady of the equine species, is readily transmissible to man with very serious results. Fortunately, the disease in horses has been practically eradicated from the United

*Presented at Medical-Military Symposium, U. S. Naval Hospital, Philadelphia, Pa., October 1950.

VETERINARY SERVICE

States. On the other hand, during World War II the malady was prevalent in a number of places where we had U. S. troops and it constituted a hazard to the health of soldiers who directly or indirectly came in contact with infected animals. Until relatively recently the disease has nearly always been fatal both in lower animals and man. Since the advent of the sulphonamides, however, the malady can be successfully treated and cure effected. Glanders is also a disease which might be thought of if an enemy were to undertake the use of biological warfare against us.

Closely related to glanders, but still more serious, is a malady known as melioidosis. Fortunately, this disease has not been known to exist but in one or two localities in the world (Burma). Under circumstances of rapid transportation by airplane between remote parts of the world it is conceivable that in time of war a malady of this sort might make its appearance in places where it has heretofore been entirely unknown.

"Q" Fever, a rickettsial disease of several species of animals including cattle, is readily transmissible to man. The disease was first recognized among meat workers and slaughter house employees in Australia in 1935. Several years later (1938) the disease was recognized in the United States. Apparently the malady can be transmitted to man in several ways. It is thought that infection may occur through the nasal passages and that it can also be transmitted by ticks. It will be readily understood, therefore, that with soldiers in the field this condition might become more prevalent than is ordinarily the case. More recently milk has been found as a mode of transmission of this disease.

Leptospirosis has become quite common among dogs in the United States. The canine malady is due to Leptospira canicola which is a different species from that (Leptospira icterohaemorrhagiae) ordinarily causing the disease in man. The canine variety, however, is entirely capable of infecting man. During the war it was found that a considerable number of dogs assembled at War Dog Reception and Training Centers were affected with leptospirosis as determined by the agglutination test for the disease. Under the circumstances, infected animals at such places were not only a hazard to others of the many dogs congregated there but likewise a menace to the human population present. Further, after assembling animals at these centers it was apparent that if attention was not paid to the possibility of leptospira infection, the disease would be widely spread when the infected dogs were transferred from the training centers to various posts and stations throughout the military service and when returned to their homes after the war.

Another disease of lower animals transmissible to man, and which can take on added importance during a war emergency when there are numerous troops in the field, is equine encephalomyelitis. While the horse is no longer an important factor in modern armies, equine encephalomyelitis does not depend upon the equine for its perpetuation. The virus of this disease is capable of invading many species of animals, including birds, and very often, particularly in birds, it is found harbored by an animal without producing manifest evidence of the infection. As it is commonly mosquito transmitted, a large number of troops living under field conditions are more likely to exposure to the infection than when back in garrison stations. It may be recalled that during the early days of the war one of the largest outbreaks of the equine type of encephalomyelitis in man made its appearance in several of our middle western states. This happened to be in the civilian population rather than among troops.

Another factor of importance in connection with animal diseases transmissible to man, and which has heretofore been alluded to, is the introduction of exotic maladies into the country as a result of extensive and unusual travel, at a rapid rate, between different countries and remote places. When the submarine menace became serious off of our East coast during the early days of World War II consideration was given to rushing the proposed Pan-American Highway to completion in order that we would be in a better position to insure supply to the Panama Canal Zone. When this was contemplated it was realized that there were a number of diseases of lower animals, as well as of man, peculiar to some of the Central American countries which might be introduced, not only into one another of those countries, but also eventually into the United States. Because of the possibilities, the United States, with the cooperation of the countries involved, undertook a survey of both human and animal diseases in the various Central American countries during the war with a view to developing ways and means for the prevention and spread of such diseases by way of the proposed Pan-American Highway.

(To be concluded)

PROFESSIONAL SERVICES

ACHIEVEMENTS IN MILITARY MEDICINE

By

Major General R. W. Bliss

Throughout the ages, medical advancement has been almost the only universally beneficial by-product of war. Amid the pressures of armed conflict, scientists and physicians in and out of uniform have sought and found ways to alleviate suffering and save life. At times the practices and improvisations of wartime emergency have showed the way toward achievements of lasting value, not only in the Army but among civilian populations in every quarter of the globe.

The advances scored by Army medical researchers in the conquest of yellow fever and of typhoid are already well known. Yet these are only two of the many achievements which can be credited to Army doctors. By the time the United States entered World War II they had eliminated from the United States Army a number of diseases which had decimated armies throughout history--killers such as typhoid, typhus, plague, cholera, tetanus and yellow fever.

In World War II, new medical lessons and discoveries played an important and effective role in reducing the U. S. Army's losses from disease and injury to the lowest rate ever reached up to that time. The names of some of these discoveries--the sulfa drugs, penicillin, blood plasma, DDT--are now household words. Others are less well known outside of medical circles--atabrine, the acrylic eye and other prosthetic improvements, the great advances made in surgery of the skull, nerves and chest, in orthopedic and plastic surgery, in neuropsychiatry, and in fact every branch of science allied to medicine.

Since the end of World War II, the Army's medical and allied scientists have forged constantly forward in all branches of preventive and curative medicine. An outstanding example is the success scored with chloramphenicol, one of the so called "wonder drugs" whose possibilities have not yet been fully exploited. Discovered and developed by civilian researchers, the amazing properties of this drug were largely made known by Army Medical Service.

Chloramphenicol was first found to be effective against scrub typhus and typhoid fever--diseases which are of minor importance in the United States but which are serious threats in various areas of Europe, Asia and the Southwest Pacific. It is the current drug of choice against spotted fever, various streptococcal and other suppurative infections, Friedlander's and virus pneumonia, chancre, influenza, whooping cough, bacillary dysentery, undulant fever, scrub typhus, typhoid fever and paratyphoid fever. It is useful as an alternative drug against diphtheria, gonorrhea, psittacosis, plague and Q fever. It is still being tested against other diseases.

Another important postwar development is dimenhydrinate found in Army tests to be highly effective in the prevention and cure of seasickness and other forms of illness due to motion.

The Army's traditional interest in preventive medicine has long made its physicians and allied scientists recognized leaders in many phases of public health. Working in the field of insect and rodent control, Army epidemiologists, entomologist and sanitary engineers are constantly discovering new or better ways of using DDT and other weapons against the insects and animals which are the world's most formidable carriers of man-killing diseases.

Perhaps one of the most potent of the new weapons will be actidione, an antibiotic whose rodent-repellent qualities were discovered last year at the Army Medical Center in Washington. It was found that rats and mice would die of hunger or thirst rather than eat or drink anything contaminated with actidione. They would not even gnaw through a tin cardboard wrapping treated with tiny amounts of the drug to get into a package of grain or other food. Still too expensive and too toxic for general use, actidione is undergoing further experimentation by Army scientists.

Chloroquine, a preventive aid which has thoroughly proven its worth in suppressing malaria, is now issued routinely to all Army personnel assigned to malaria-infested areas. The drug has marked advantages over quinine or atabrine since only one tablet will protect a person for as long as a week.

Rheumatic fever, a menace to civil health as well as a serious military problem, has been studied seriously by Army physicians, who noted that most cases of the disease are preceded by streptococcal infection. Preliminary conclusions indicate that rheumatic fever can be prevented by penicillin treatment of the streptococcal disease. The importance of this discovery--if continued investigation bears out the preliminary report--is far reaching, for rheumatic fever annually strikes more than 200,000 Americans causing over 30,000 deaths.

A vaccine developed at the Army Medical Service Graduate School, today gives some protection to our soldiers in the Far East against Japanese encephalitis, a form of sleeping sickness. Every American soldier assigned to that area is now vaccinated against this disease.

The Army Hepatic and Metabolic Center--a part of the Army Medical Center in Washington, D.C.--has been carrying on intensive studies of disease of the liver, with particular emphasis on infectious hepatitis. The disease is curable by bed rest and a highly nutritious diet over a comparatively long period of time but no specific satisfactory treatment for it has yet been developed. During World War II infectious hepatitis hospitalized more than 200,000 United States troops in all theaters, with an average period of hospitalization of two to three months. Intensive research continues, spurred on by the knowledge that such a loss of effective strength can be a disaster to an army in the field.

Considerable progress in Army medical research has been reported from Korea. New items being tested on that distant battleground include: a disposable sterile injection device for the administration of drugs in the field, a new stainless steel bone pin for fractures, portable anesthesia apparatus, an oversize burn or wound dress and a lighter and stronger replacement for plaster of paris in fracture cases. The hormones ACTH and cortisone are being field-tested to study their value in retarding the growth of fibrous tissue and decreasing scar formation in wounds. Also being tried out are new uses for various antibacterial drugs.

Most of these developments for the aid and comfort of sick and wounded soldiers spring from the work of the Surgeon General's Research and Development Board and have been under trial in Army hospitals in the Zone of the Interior for varying lengths of time.

The injection device, which can be discarded after use, is a sterile needle attached by a rubber tube to a glass container partially filled with penicillin, streptomycin or some other liquid drug. The remaining space is occupied by helium gas under pressure. By breaking a seal which releases the compressed gas, the drug is forced through the needle into a tissue.

PROFESSIONAL SERVICES

A civilian medical consultant to the Surgeon General recently returned from Korea where he supervised the field testing of two new drugs--methadon and levo-iso-methadon--in evacuation hospitals. These drugs, termed "perfect substitutes for morphine," had been tested in the United States.

Preliminary work on methadon had been done in Germany and later the Army's research team perfected the new synthetic. Final validation has now been made under the most rigid conditions and methadon or levo-iso-methadon will eventually be adopted by the Army as a standard item.

As a result of this development the United States and the western world for the first time in history are less dependent upon Asia and the Near East for narcotic drugs to relieve pain, since methadon can be made at comparatively low cost from substances which are abundant in the United States. It may well be that the discovery of methadon will rank among the great contributions of military medicine to world health.

The steel bone pin, too, can be traced to groundwork done by the Germans prior to and during World War II. Called an intramedullary pin because it is inserted into a marrow cavity, it was tested and improved by ten military and civilian orthopedic surgery clinics working under Army auspices. The devices were recently tried out for several weeks in Tokyo Army Hospital. Used thus far only for breaks in the femur (the long bone of the thigh) it aroused such enthusiasm among Army surgeons in Japan that they asked for similar pins for fractures of other bones. The Surgeon General's Office is now arranging for the fabrication of such pins.

The intramedullary bone pin has many advantages. The patient suffering a leg fracture can exercise in bed almost as soon as the operation is over. He is able to walk after six or eight weeks, instead of several months as formerly. The new pin eliminates the need for a plaster cast; it promotes faster growth of new bone tissue, permits earlier fixation of the bone and avoids the stiffness of joints and the weakening of the leg muscles that come from immobilization in a cast.

The Army's thermal burn research program is so extensive and so important to the civilian and the soldier alike that it calls for somewhat special emphasis. At present the Army is making considerable progress in studying the treatment and rehabilitation of large numbers of casualties suffering from thermal burns, those that might be expected from the atomic bomb, other incendiaries, or major catastrophes. In these studies, advantage is taken of experiences in such disasters as the circus tent fire in Hartford, the Coconut Grove night club holocaust in Boston and the explosion at Texas City.

Extensive investigation of the "open" or "exposure method" of treating burns has demonstrated its value in relieving pain and speeding recovery. The open method of treatment is carried out without using any type of dressing. The burned surface is simply exposed to warm, dry air, with no medication, except antibiotics to prevent infection. This method eliminates painful changes of dressings and greatly reduces the need for nursing and surgical care. The open technique, however, cannot be used easily in cases where burns extend completely or almost completely around the body or a limb.

Army medical researchers have found that in cases of extensive burns--those involving more than 20 per cent of the body surface--the closed or pressure method is more applicable, and improvements in this technique have also been made. It has been found unnecessary, for example, to use petroleum jelly in treating the burn. After 21 to 28 days the patient is ready for any necessary skin grafting.

A new oversize burn or wound dressing--five times larger than any previously employed--is now in use in Korea. The inside layer of highly absorbent fine mesh gauze which is placed against the burn or wound may be treated if necessary to reduce irritation. An outside non-absorbent layer prevents the medication from soaking through and keeps bacteria from entering. The dressing--specifically designed for first aid treatment--improves the casualty's chances of reaching a hospital in good condition.

Continuing its program of unrelenting research through war and peace, the Army Medical Service remains dedicated to its basic mission: To prevent disease and injury among American troops to the fullest extent possible and to give to the sick, injured or wounded soldier the best care that modern scientific knowledge, human ingenuity and personal interest can provide.

(The above article is from Army Information Digest, Vol. 6, No. 6, June 1951)

* * *

EFFECT OF THE NATIONAL EMERGENCY ON THE ELIGIBILITY REQUIREMENTS FOR BOARD CERTIFICATION

Presented by:

Colonel Floyd L. Wergeland

Chief, Education & Training Division, OSG, D/A
at the Meeting Advisory Board for Medical Specialties.
Congress Medical Education & Licensure, 11 February 1951.

For a proper background to the discussion of this subject I would like to go back to the early part of 1950. At that time it was obvious that by May 1950 the shortage of Medical Corps officers would be extremely critical due to the separation of medical officers completing their service requirements. To alleviate this situation, residents were removed from the training program for temporary duty of ninety (90) to one hundred and twenty (120) days pending the arrival of replacements from the intern group. These men were assured that they would be returned to their residency and that their period of training would be extended by a sufficient length of time to enable them to meet the requirements of their Specialty Board.

The onset and continuation of the Korean Affair delayed the rotation of many of these residents to their training program; however it is anticipated that they will all have been returned to the program by 1 July 1951. I cannot pass over the successful and wonderful part that these men played in the Korean war without paying tribute to the professional ability that these men demonstrated and to the professional graduate training program that permitted these men to gain that ability. The graduate training program contributed toward meeting the emergency generated by the Korean Affair in three ways.

1. It provided enough board qualified physicians to meet the initial need to direct and effect definitive treatment of casualties both in the Far East and at home.

PROFESSIONAL SERVICES

2. It provided an adequate number of board-qualified physicians to meet the early operating requirements for Korea in all essential specialties.

3. It provided a reservoir of medical officers to meet the immediately expanding numerical requirements of the Far East Command. I might add that this reservoir has been almost completely taken away due to the fact that a resident now fills a duty assignment space at out teaching hospitals.

In order to protect the interest of these residents during their absence from the training program the "MEDICAL OFFICERS PROFESSIONAL TRAINING RECORD" was developed on the advice of Dr. Donald G. Anderson, Secretary of A M A Council on Medical Education and Hospitals and Dr. B. R. Kirklin, Secretary of Advisory Board for Medical Specialties. Advice and suggestions were received from several sources. Its present and final form (Department of Defense - Form No. 408) was approved by the Department of Defense with directions that each service would print the number necessary for their own use.

At the time of printing it was obvious that many of the medical officers just entering the military service would also want to keep a record of their professional training. Only those officers need to keep this record who are not in a recognized training program and who anticipate applying for certification at some future date. Instructions for maintaining it are printed on the inside of the cover. They are available to all medical officers in the Armed Forces.

The Surgeon General's Professional Education Committee raised several questions at this time in reference to Board Credit for non-residency training. It was suggested that I, as Chairman of the Committee, write to Dr. Anderson to seek assistance thru Dr. Kirklin in determining the answers to these questions from various specialty boards. These questions were submitted as suggested. Dr. Kirklin submitted three (3) similar questions to each Specialty Board at the request of the Joint Committee on Medical Education in Time of National Emergency. Since both sets of questions were similar, I will discuss only those submitted by the Joint Committee.

These questions were:

1. Will your Specialty Board give preference to those candidates wishing to be examined before going overseas or entering military service?

2. How much, if any, credit toward your training and/or experience requirements will your Board allow candidates while in military service?

3. Do you approve of the Record of Professional Assignments which has been drawn up by the military service?

The answers to questions one and three can be summarized briefly.

To question Number One the American Board of Orthopedic Surgery answered "not necessary". All other Specialty Boards answered "yes".

To question Number Three, sixteen (16) Boards answered O.K.

Board of Dermatology and Syphilology made no reply.

The answers to question Number Two cannot so easily be summarized and I will take a few minutes to read the answer of each Specialty Board.

AMERICAN BOARD OF OPHTHALMOLOGY

No stated credit--each case decided according to the time the candidate has spent assigned to a military hospital in Ophthalmology, etc.

AMERICAN BOARD OF OTOLARYNGOLOGY

Credit is given, but each case is determined on its own merits.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Six (6) months to three (3) years, depending on assignment. For post-training practice credit, full-time credit will be given as substitute.

AMERICAN BOARD OF DERMATOLOGY AND SYPHILOLOGY

Automatic credit is allowed for one (1) year toward the experience requirement plus credit for training in individual cases.

AMERICAN BOARD OF PEDIATRICS

One (1) year of credit, regardless of assignment, towards two-year practice requirement.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

Held in abeyance until discussion at Advisory Board meeting, February 11, 1951.

AMERICAN BOARD OF RADIOLOGY

One (1) year if assignment is in Radiology.

PROFESSIONAL SERVICES

AMERICAN BOARD OF ORTHOPEDIC SURGERY

One (1) year of practice credit and one (1) year of residency credit. Same year cannot be credited for both residency and practice credit.

AMERICAN BOARD OF UROLOGY

No credit for training but credit for one year of practice requirement if training was complete when entering service.

AMERICAN BOARD OF INTERNAL MEDICINE

One (1) year of graduate training credit or one (1) year in partial satisfaction of practice requirement. Additional credit on the merits of each individual case.

AMERICAN BOARD OF PATHOLOGY

Allows liberal credit toward training when assigned to a good Department of Pathology, but candidate must first have had a minimum of one (1) year residency in an approved civilian Department of Pathology.

AMERICAN BOARD OF SURGERY

Credit is allowed, but each case is decided on its merits.

AMERICAN BOARD OF ANESTHESIOLOGY

Formal Training credit only for approved residency. Allow practice credit if assigned to anesthesia service.

AMERICAN BOARD OF PLASTIC SURGERY

Credit given on individual basis, considered on own merits.

AMERICAN BOARD OF NEUROLOGICAL SURGERY

Credit will be allowed on training requirement if candidate is assigned to Neurologic Surgery in a military hospital; also, credit will be allowed for practice requirement if assigned to Neurologic Surgery.

AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION

Maximum of one (1) year credit in related field; full credit if in the specialty.

AMERICAN BOARD OF PREVENTIVE MEDICINE AND PUBLIC HEALTH

Full credit if service is in the specialty; a maximum of six (6) months for general military duties.

AMERICAN BOARD OF PROCTOLOGY

One year in fulfillment of either general surgical or proctologic requirements.

On the whole the Specialty Boards have been extremely fair and just and we appreciate having this information and it will help our personnel division a great deal in making assignments.

In order to forestall some questions, and also to assure the various specialty boards of the justice of the formal and practice credit they are allowing candidates who are in the military service, I wish to point out that a professional training program is directed in all our Station Hospitals. This program is not as extensive as that carried on in our teaching hospitals but are on a par with that carried on at many smaller hospitals throughout the country, which are approved for residency. In the majority of these hospitals the Chiefs of Services and/or Section are Board-qualified, many certified. All have a well qualified group of local civilian consultants as an attending staff. With this in mind I feel that the Specialty Board should give full credit toward residency training for the time served in a specialty under a certified Board man in a hospital with an adequate teaching program and qualified attending staff and that this credit should be given to the individual whether he is a Draftee, Reserve or Regular officer.

I would like to point out that in the military service we are limited by tables of distribution (that is we all allowed to have no more than a specific number of physicians at each hospital); that this number has been pared down to a minimum; that each resident counts against this number; and that finally the number of residents has been currently limited to approximately three hundred.

Newly commissioned medical officers will be given a four (4) weeks orientation course at Medical Field Service School, Fort Sam Houston, Texas. This course was established to orient new officers to the military service and give some training in tactics and techniques of combat medical units. After completing this course the medical officer will be assigned according to his (MOS) specialty in so far as possible with military necessity. Those physicians who have completed their formal residency training will be assigned in their specialty. After these have been assigned, personnel assignment authorities must face a realistic problem; on the one hand most of the doctors coming on duty will have had a certain amount of specialty training and on the other hand the Army has many assignments for general duty medical officers who do not need any specialized training. When all the general duty officers (3100) have been assigned to such duties and vacancies still exist, then officers with some specialty training will have to be assigned to fill them. Every practicable effort will be made to advance the individual medical officers' education and training in the field of his specialty. We sincerely hope his time in the Army will, therefore, be profitable to him and to The Nation.

NURSING SERVICE

CAMPAIGN FOR COURTESY

By

F. Margaret Nelson, R.N.

"Baylor Employees Declare War on Discourtesy!!" This headline in our hospital newspaper aroused the curiosity of the entire staff. The article following the headline went on to describe a four-month, five part-campaign planned to encourage all hospital employees to be more courteous. The campaign originated because several observant members of the staff noted that the personnel shortages and overcrowded wards of the war years had left a terrific hangover of undesirable attitudes among staff members. Hectic days and nights had fostered unintentional loss of good temper and good manners. Brusqueness had too often replaced politeness and kindness; carelessness in interpersonal relationships was producing friction between hospital groups as well as between the hospital family and the public.

With the full approval of the hospital administration, the following campaign plan was presented in the hospital newspaper:

1. Each employee was urged to consider seriously the meaning of courtesy and to put his understanding of the word into every day practice.
2. Each employee was asked to submit original courtesy slogans which all Baylor Hospital employees could adopt and really use every day.
3. Each employee was given an opportunity to submit an original essay entitled "What is Courtesy?"
4. Each employee was promised an opportunity to see interesting films about courtesy.
5. Patients, doctors, and employees were asked to help select the most courteous employee in Baylor Hospital. Special forms and ballots for voting would be made available to all when the campaign started.

The newspaper article did not stop there. In bold-faced type, to attract the attention of those who might tend to ignore the information and suggestions, we read, "You are not interested? Oh, you will be--read a little farther!" This list of awards to be presented to the various contest winners followed: a \$25 Savings Bond to the person chosen as the most courteous employee in Baylor; a \$25 Savings Bond to the person writing the best original essay of not more than 300 words on "What is Courtesy?"; a \$5 fountain room ticket book for each of the two next best essays; and, for the three next best a \$3 fountain room book; for each original slogan which was accepted and used, a \$3 fountain room book. All slogans had to be submitted during the first month of the campaign so that those which were accepted could be used throughout the remainder of the project.

Well, the contest clinched the plan. Like most good Americans we reacted favorably to this approach, just as we do to radio give-away programs!

Although the paper had printed a sample essay to give us some idea of what was wanted, there was considerable discussion about the meaning of the word "courtesy." Nurses and other members of the staff could be heard analyzing the word and considering ways of putting their interpretation of it into action.

Two interesting films were shown--one during the first week and the other in the third month of the program. Both pictures were shown several times daily for three days and time was arranged for every employee to see them. The pictures were humorous and meaningful, and many catch phrases from them were bandied about by all of us.

One brief phrase of "mood music," which sounded like the musical theme of one of the movies we had all seen, was played softly over the loud speaker at infrequent and unexpected moments to remind us that courteousness was to be expressed in action.

The winning slogans, printed on brightly colored paper, were posted in conspicuous places throughout the hospital. The winning essays were published in subsequent issues of the "Baylor Progress," our hospital newspaper. We were delighted that a considerable number of prize-winning slogans

NURSING SERVICE

and essays were contributed by supervisors, general staff nurses, student nurses, and attendants,

Consciously or unconsciously, attitudes improved during the first month of the contest. By the third month, voting for the most courteous employee had become very active. The ballots, which were deposited in a large box at the information desk, were collected daily and tallied by an impartial committee selected by our administrator. It was interesting to note how few employees receive no votes!

The special forms for comments about especially courteous employees, which had been distributed to doctors, visitors and patients early in the campaign, were filled out and returned to the administrator and the campaign committee. They revealed a great deal about the attitudes of nurses and attendants and showed a definite upswing in favorable nurse-patient relationships after the courtesy drive started. Patients, who had been in the hospital during the war or the years immediately following and who were readmitted while the campaign was in progress, commented upon the improvement in kindly personal consideration which had developed since their previous admissions.

Knowing that courtesy in the form of kind words can act like a strong tonic, the editor of our paper printed the complimentary statements from the questionnaires in a column entitled "Orchids to You." Our staff nurses were highly pleased--and so were we--when their names were included in statements like these:

I think every nurse and employee has done everything possible to make our stay a pleasant one. They are all extremely nice.

The nursing staff was very helpful and nothing was overlooked to make my week in the hospital pleasant and comfortable.

All the nurses have been efficient and have gone out of their way to make things pleasant here.

Regarding the service of the nurses, we were pleased with the courtesy that we received because we had heard rumors of inefficiency and carelessness in hospitals. We entered the hospital with a slight chip on our shoulders expecting a certain amount of cold-bloodedness and inconsiderate business-like methods. The first day held a great many surprises. We had told our friends that we were made to feel as if the entire hospital personnel had nothing else in mind whatsoever except the complete comfort of my wife.

The campaign was extremely profitable not only to the hospital and its public relations efforts but to each member of the nursing staff. We learned that a few moments spent in kindly explanation and polite consideration paid off in personal dividends. By being courteous ourselves at all times, we obtained the good will and co-operation of doctors, visitors, and patients; consequently our work became more pleasant.

Several months have elapsed since the end of the campaign but the "orchids" continue to arrive. This indicates to us that the members of our nursing staff have not lapsed into their former thoughtless habits. We hope that we may continue to practice courtesy and urge others to accept the advice contained in a winning slogan that was written by one of our nurses--Create confidence with courtesy!

A Nurse Says:

"CREATE CONFIDENCE WITH COURTESY"

A Laboratory Technician Says:

"COURTESY, LIKE SOME DISEASES,
CAN BE CONTAGIOUS...GET A
GENUINE CASE AND START AN EPIDEMIC."

A Maintenance Man Says:

"COURTESY IS KINDNESS
EXPRESSED IN ACTION"

A Switchboard Operator Says:

"COURTESY--THE KEY TO SOUND
BUSINESS, GOOD WILL, AND KIND
REMEMBRANCE"

(The above article is from "The American Journal of Nursing" June 1950, Vol 50, No. 6, Page 326-7)

RESTRICTED

PREVENTIVE MEDICINE

GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army Medical Service installations do not include Air Force personnel. (See General Data and Admissions Tables on page 15).

The non-effective rate* decreased from the May rate of 15.26 to 14.32 for the month of June. Days lost as a result of disease and injury totaled 11,350 during the four week period ending 27 June 1951.

*Non-Effective Rate -- $\frac{\text{Total Days lost} \times 1,000}{\text{No. of Days in Period} \times \text{Average Daily Strength}}$

Non-Effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in June was 388.2, compared to 382.8 during May. Total admission for disease and injury in June was 843. Of this number 720 admissions were for disease and 123 injuries. Fort McNair reported the highest admission rate, and U. S. Army Dispensary, The Pentagon reported the lowest rate during the current month.

**Admission Rates -- $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

June's rate for disease cases is 331.5 for 720 cases. Fort McNair reported the highest admission rate, and U. S. Army Dispensary, The Pentagon reported the lowest rate for disease cases.

An injury admission rate of 56.6 per 1,000 per annum for June was reported. This was an increase over the May rate of 55.7. For Myer reported the highest rate and All Other reported the lowest rate for injuries.

There was one death reported during the four week period ending 27 June 1951, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases decreased in incidence during the month of June 1951. The rate for the present month is 72.7 compared to the May rate of 89.1. Fort McNair reported the highest rate, and the U. S. Army Dispensary, The Pentagon reported the lowest rate. Admission rates for pneumonia (all types) increased during the June report period. The rate being 15.6 compared with the May rate of 9.3. There were no cases of scarlet fever reported throughout the month of June.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, diarrheal disease and hepatitis during the four week period ending 27 June 1951.

Pertinent statistical tables may be found on pages 16 and 20.

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

GENERAL DATA
4-Week Period Ending 27 June 1951
(Data from DD Forms 442*)

STATION	MEAN STRENGTH			All Causes		Disease		Injuries		Non-Effective Rate	Number of Deaths
	Total	White	Negro	Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Va.	16,533	14,731	1,822	533	419.72	452	355.94	81	63.79	15.52	0
Fort McNair, Wash, D.C.	813	738	75	42	673.39	37	593.23	5	80.17	9.36	0
Fort Myer, Va.	4,224	4,079	145	169	521.52	141	435.12	28	86.41	11.41	1
U.S. Army Disp, Pentagon	4,210	4,191	19	59	182.68	54	167.19	5	15.48	16.85	0
All Others	2,506	2,502	4	40	208.06	36	187.25	4	20.81	8.64	0
Total-Military District of Washington	28,306	26,241	2,065	843	388.20	720	331.56	123	56.64	14.32	1
AMC - Med Det (Duty Pers)	1,697	1,591	106	82	503.90	79	485.50	3	18.40	12.70	0

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
4-Week Period Ending 27 June 1951
(Data from DD Forms 442*)

STATION	Common Respiratory Disease	Pneumonia All Types	Pneumonia Atypical	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diarrheal Disease	Hepatitis	Malaria	Influenza	Psychiatric Disease
Fort Belvoir, Virginia	63.00	25.97	23.62	3.94	3.94	--	-	15.75	-	1.57	6.30	.79	20.47
Fort McNair, Wash., DC	208.43	-	-	-	-	-	-	32.07	-	-	16.03	-	16.03
Fort Myer, Virginia	70.98	3.09	3.09	3.09	-	-	-	12.34	-	-	-	-	-
U.S. Army Dispensary, The Pentagon	68.12	-	-	-	-	-	-	-	-	-	-	-	3.10
All Others	104.03	-	-	-	5.20	-	-	-	-	-	-	--	-
Total-Military District of Washington	72.76	15.66	14.28	2.76	2.76	-	-	11.97	-	.92	4.14	.46	12.89
AMC-Medical Detachment (Duty Pers)	411.70	6.10	6.10	6.10	-	-	6.10	-	-	-	-	-	-

*Statistical Data previously reported on WD AGO Form 8-122, is now reported on DD Form 442.

EXPERIENCES BETWEEN WORLD WARS

Military preventive medicine between the world wars was conditioned largely by the experiences of World War I. Good sanitation and disease control characterized the health protection of a small army largely garrisoned on small posts. Training doctrine and development was kept alive in the Medical Field Service School, and in the Army Medical School, but except for the medical inspectors of commands, there was no formal Preventive Medicine organization as such, up to and including the Surgeon General's office in the War Department.

World War II saw the rapid organization and development of preventive medicine throughout the Army's framework under the able guidance of Brigadier General James Stevens Simmons. Mobilization for war on a global scale and the Japanese attack in 1941 placed great emphasis upon sanitation and the control of disease in the tropics. Army experts in organization, administration, and the technical aspects of military preventive medicine teamed with the civilian public health profession, and laboratory and investigative experts in uniform to forge a vast preventive medicine service, the work of which was largely responsible for the favorable communicable disease record.

(The above is extracted from the article "Military Preventive Medicine" by Colonel Tom F. Wayne, MC, published in HEALTH NEWS, Vol 28, No. 3, March 1951, New York State, Department of Health)

RESTRICTED

RESTRICTED

PREVENTIVE MEDICINE

VENEREAL DISEASE

Venereal Disease rate among units within The Military District of Washington, increased during the June report period.

The rate for June 1951, was 16.58, an increase over the May rate of 8.52. A total of 36 cases reported for the four week period ending 27 June 1951. Of this total 29 were reported by Fort Belvoir, 5 cases for Fort Myer, and 2 cases for Fort McNair.

During the report period, white personnel incurred 13 of the reported number of cases, with a rate of 6.46 and 23 were incurred by Negro personnel with a resulting rate of 145.18 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designated station, we have undertaken to report the number of cases per 1000 men for this report period (June) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 17, 18 and 19

NEW VENEREAL DISEASE CASES - EXCEPTS - APRIL, MAY AND JUNE 1951

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	APRIL 1951	MAY 1951	JUNE 1951	JUNE 1951
Fort Belvoir	14.68	14.76	22.84	1.751
Fort McNair	15.95	-	32.07	2.460
Fort Myer	3.82	-	15.43	1.183
U.S. Army Dispensary, Pentagon	-	-	-	-
All Others	-	-	-	-
Total - Military District of Washington Units	9.89	8.52	16.58	1.271
Army Medical Center - Medical and Holding Detachments	9.18	-	4.14	.317
Total - Dept/Army Units Military Dist/Wash.	9.83	7.67	15.33	1.176

CHARACTER GUIDANCE IS A COMMAND RESPONSIBILITY

The character guidance program has been devised to assist the commander in promoting a healthy moral and mental attitude on the part of the personnel under his command. Under this program the commander will endeavor to insure, so far as is possible under the conditions of military service, the continuance of the wholesome influence of the home, the family, and the community. The program is broad in its application, positive in its approach, and embraces all the activities of the soldier. It is designed to encourage the individual to develop moral responsibility and self-discipline.

Generally, the character guidance program is intended to develop high standards of personal conduct among members of the Army.

(The above is extracted from AR 15-120, dated 28 July 1950)

RESTRICTED

CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY
MDW RATE PER 1000 TROOPS PER YEAR

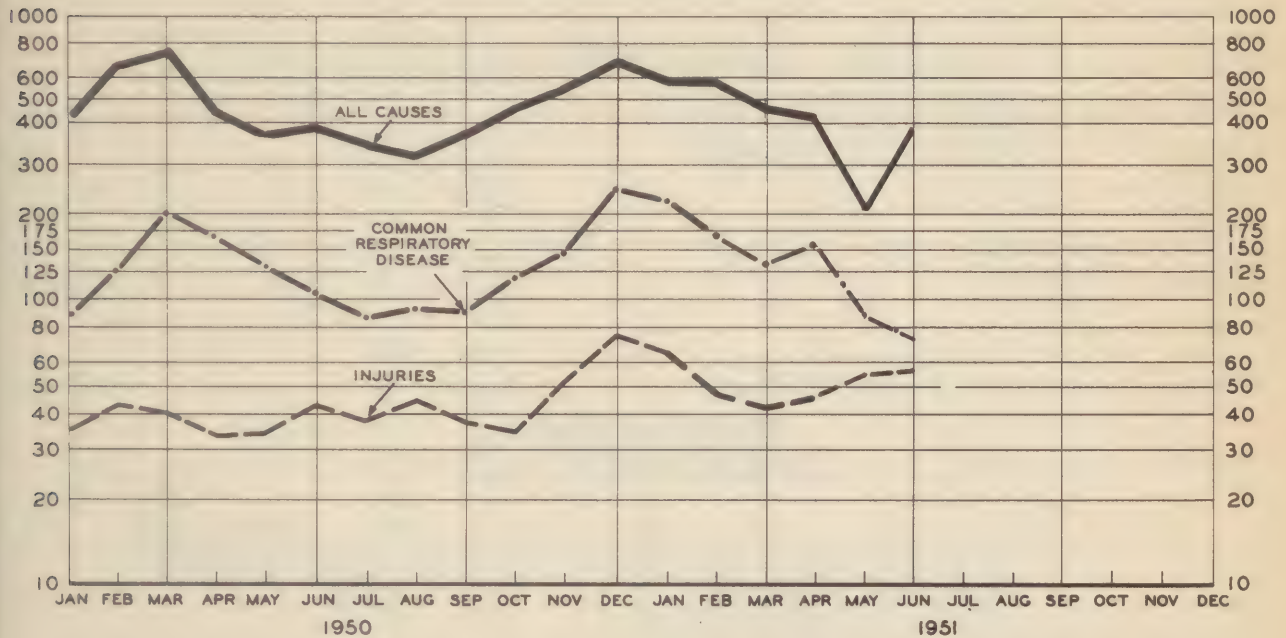
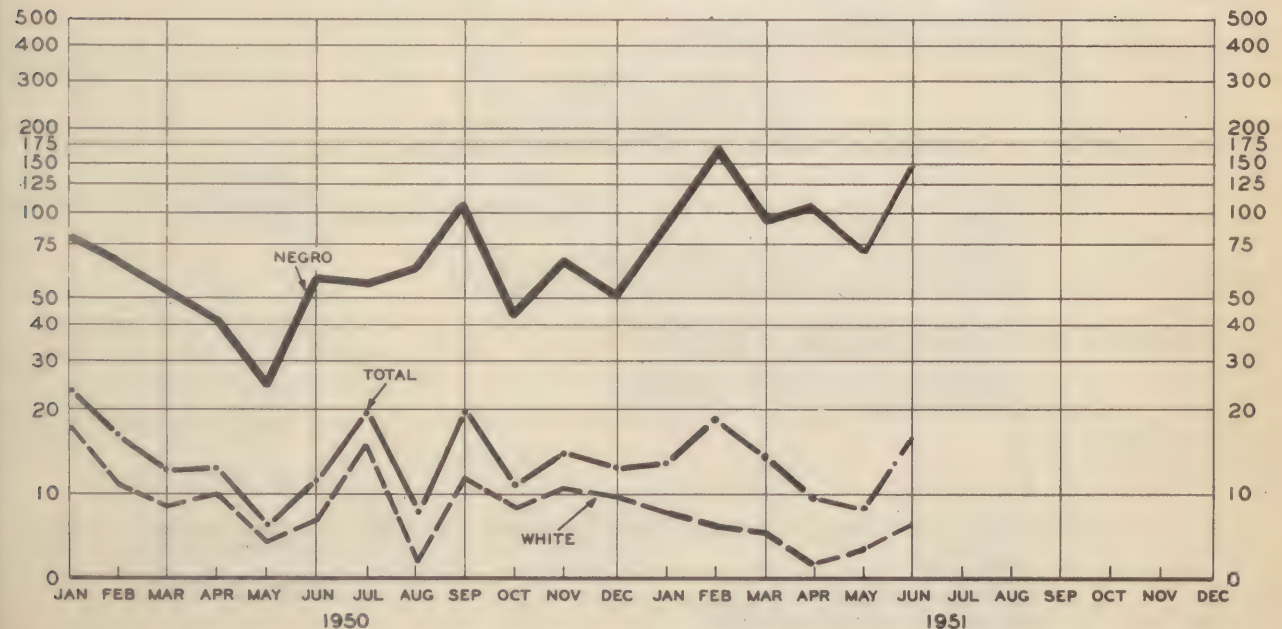


CHART 2

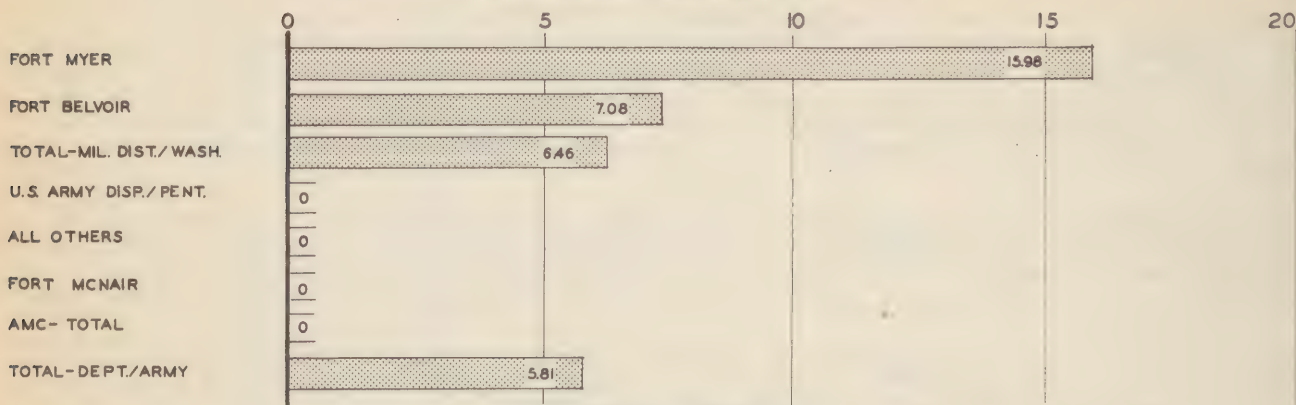
ADMISSION RATES BY MONTH VENEREAL DISEASES MDW NOT INCL. ARMY MEDICAL CENTER
RATES PER 1000 TROOPS PER YEAR
INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTS



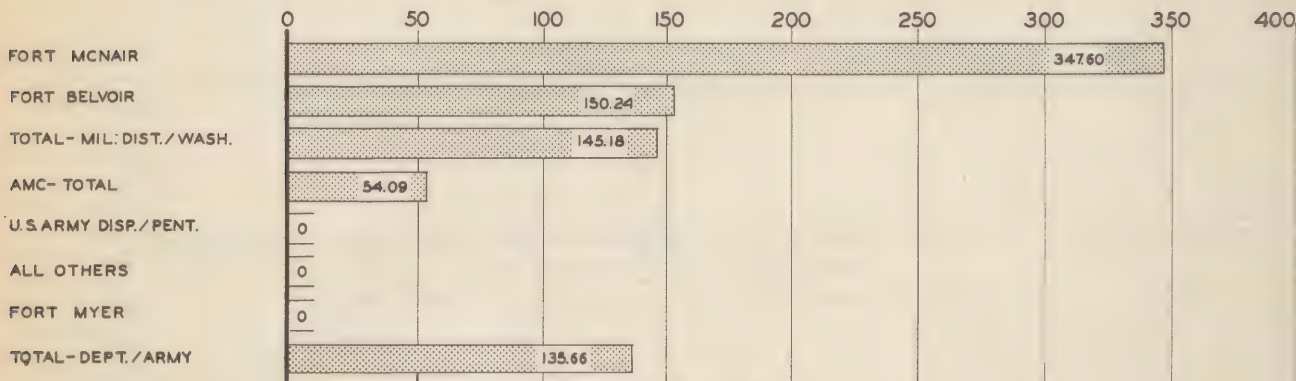
PREVENTIVE MEDICINE

RESTRICTED

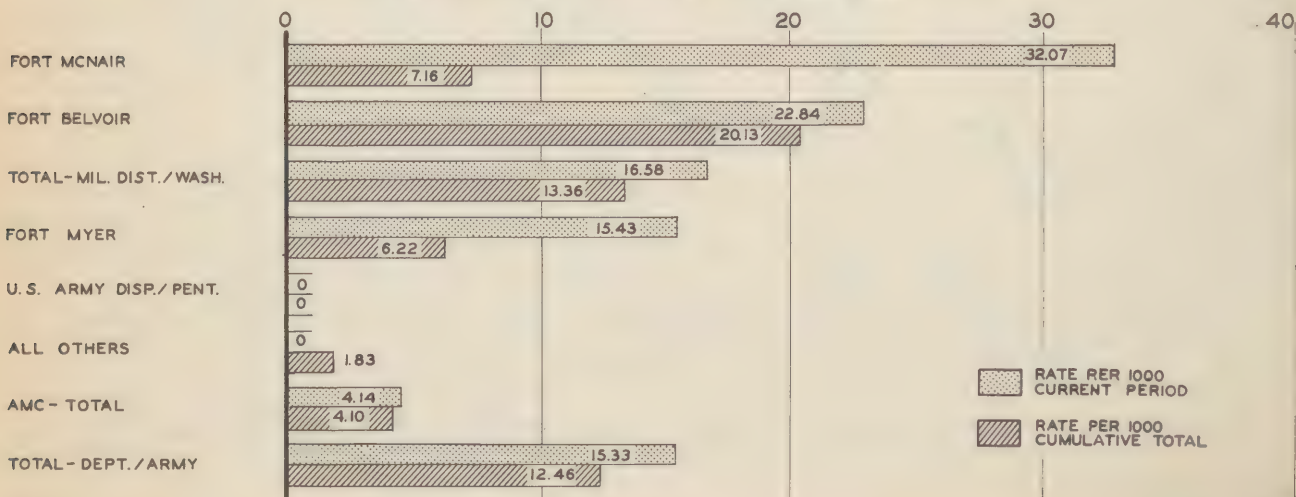
VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 27 JUNE 1951 WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 4 WEEK PERIOD ENDING 27 JUNE 1951 NEGRO PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATES PER 1000 PER YEAR FOUR WEEK & CUMULATIVE TOTALS ENDING 27 JUNE 1951 TOTAL WHITE & NEGRO PERSONNEL (CHARGEABLE CASES)



RATE PER 1000 CURRENT PERIOD
 RATE PER 1000 CUMULATIVE TOTAL

PREVENTIVE MEDICINE

RESTRICTED

CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT

For the Four Week Period Ending 27 June 1951

(Data from DD Form 442*) (Chargeable Cases)

STATION	R A C E	Mean Strength	Syphilis	Gonorrhea	Other	Total	Rates per 1000 Troops per Annum
Fort Belvoir	W	14731	1	7	0	8	7.08
	N	1822	2	19	0	21	150.24
	T	16553	3	26	0	29	22.84
Fort McNair	W	738	0	0	0	0	-
	N	75	0	2	0	2	347.60
	T	813	0	2	0	2	32.07
Fort Myer	W	4079	0	5	0	5	15.98
	N	145	0	0	0	0	-
	T	4224	0	5	0	5	15.43
US Army Dispensary The Pentagon	W	4191	0	0	0	0	-
	N	19	0	0	0	0	-
	T	4210	0	0	0	0	-
All Others	W	2502	0	0	0	0	-
	N	4	0	0	0	0	-
	T	2506	0	0	0	0	-
Total-Military District of Washington	W	26241	1	12	0	13	6.46
	N	2065	2	21	0	23	145.18
	T	28306	3	33	0	36	16.58
Army Medical Center	W	2908	0	0	0	0	-
	N	241	0	1	0	1	54.09
	T	3149	0	1	0	1	4.14
Total-Dept/Army Units	W	29149	1	12	0	13	5.81
	N	2306	2	22	0	24	135.66
	T	31455	3	34	0	37	15.33

* Statistical Data previously reported on WD AGO Form 8-122, is now reported on DD Form 442.

VENEREAL DISEASE RATES*

(All Army Troops)

	APRIL 1951	MAY 1951	JUNE 1951
First Army Area	11	15	21
Second Army Area	18	20	22
Military District of Washington	10	8	16
Third Army Area	20	19	30
Fourth Army Area	27	29	48
Fifth Army Area	15	17	19
Sixth Army Area	47	29	30
TOTAL United States	22	21	28

*Compiled in the Office of the Surgeon General and Includes US Army Hospitals

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

DENTAL SERVICE - FIVE WEEK PERIOD ENDING 27 JUNE 1951

STATION	Military		Civilian		Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Ex- trac- tions	Calcu- lus Re- moved	X- Rays	Exami- nations
	Men	Duty Days	Men	Duty Days									Full	Par- tial	Re- pair				
Fort Belvoir	30	681	1	5	6827	2556	1400	570	5	16	20	16	34	58	39	1458	464	1472	1542
Fort McNair	2	60	0	0	301	92	111	47	2	0	1	0	4	8	2	30	27	121	68
Fort Myer, Va.	5	138	1	10	1988	548	142	103	1	3	5	8	5	34	7	188	153	811	335
US Army Dispen- sary, Pentagon	7	190	0	0	1798	457	224	145	2	5	15	4	11	25	19	99	201	452	543
All Others	4	108	0	0	1028	271	74	60	0	4	2	2	8	10	4	329	51	115	1012
Total - MDW	48	1177	2	15	11942	3924	1951	925	10	28	43	30	62	135	71	2104	896	2971	3500

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DAIRY PRODUCTS INSPECTED JUNE 1951 (Date obtained from WD AGO Form 8-134)

STATION	CLASS* 3	CLASS* 4	CLASS* 5	CLASS* 6	CLASS* 7	CLASS* 8	CLASS* 9	TOTAL
Fort Lesley J. McNair		54,417	140,172		216,672		52,010	468,271
Fort Belvoir, Virginia		583,172	330,869		1,084,269	164,126	387,443	2,549,879
Alexandria Field Buying Office		587,871	210,385	770,852			140,076	1,709,184
Fort Myer, Virginia		148,896	190,990		312,254	15,224	163,137	830,501
Cameron Station, Virginia		153,414	144,592		320,195	8,189	85,362	711,752
MDW Veterinary Detachment	808,129							808,129
The Pentagon						327,880		327,880
Army Medical Center		180,699	174,107		361,486	13,419	63,374	793,085
Total	808,129	1,713,469	1,191,115	770,852	2,294,876	528,838	891,402	8,198,681
REJECTIONS:								
Not type Class or grade								
Alex. Field Buying Office		1,077						1,077
MDW Veterinary Detachment	5,625							5,625
Insanitary or Unsound								
Alex. Field Buying Office		1,704						1,704
Cameron Station, Virginia		120						120
MDW Veterinary Detachment	23,664							23,664
TOTAL	29,289	2,901						32,190

*Class 3 - Prior to Purchase

*Class 4 - On delivery at Purchase

*Class 5 - Army Receipt except Purchase

*Class 6 - Prior to Shipment

*Class 7 - At Issue

*Class 8 - Purchase by Post Exchange, Clubs
Messes or Post Restaurants

*Class 9 - Storage

OUTPATIENT SERVICE

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the 33 day period ending 27 June 1951:

ARMY:

Number of Outpatients 13976

Number of Treatments 16088

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 1140

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 11375

NON-ARMY

Number of Outpatients 16812

Number of Treatments 18499

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 1140

NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 11375

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION	MARCH 1951	APRIL 1951	MAY 1951	JUNE 1951
Fort Belvoir				
Income per Ration	\$1.254	\$1.2999	\$1.2996	\$1.3178
Expense per Ration	1.135	1.2716	1.2549	1.2453
Gain or Loss	+1.18	+0.0283	+0.0447	+0.0725

RESTRICTED

HEALTH MAINTENANCE OF KEY PERSONNEL

The Health maintenance of personnel is a corporate problem. Machines can be replaced, as the men who run them. What cannot be replaced at will is the 10, 20, or 30 years of executive experience which is the most expensive factor of all.

Each key employee represents a substantial financial investment. As an executive, it is his duty to protect the company from financial loss by conserving his own health to the greatest extent possible. At no time in the history of our country has the health of the executive been so vitally important as it is now. In times such as these, the executive's health is not entirely a personal problem between his employer and himself, rather, he has now, in addition, a patriotic responsibility.

It is imperative for each employee to know what his health is, and to learn to live within the budget nature has given him. We are convinced the issue can never be dodged. Meeting it head on, the earlier the better, is the only solution.

Health of key personnel is intimately associated with personal ability, job assignment, and, in fact, total environment plus reaction to it.

Each man, like a piece of machinery, shows the effects of the stresses and strains he has encountered and weathered. Each "wears" at what is essentially an individual rate which is contributed to by the stresses undergone, previous disease encountered, and the quality of the individual's own tissues, especially his vascular system.

As noted by Habelin, of the Mayo Clinic, degenerative vascular diseases are continually increasing hazards to health of modern man, especially of those persons who earn their livings by the use of their minds. A fascinating observation was made by Schwartz and Harvey when they showed that in the case of the executives of New York's financial area there is a correlation between the day-to-day incidence of coronary attacks and fluctuations of activity on the stock market! The statistics of White on the rising mortality rate for the cardiovascular diseases are a further indication of medical facts that must vitally concern all physicians whose duty it is to help maintain the health of key personnel.

It is obvious that no two individuals will react to the same set of circumstances, or will react in exactly the same pattern. This is where inherited tendencies, compensating factors, temperaments, native intelligence, etc., play their part.

The whole problem of job placement, the relation of man to his working environment, is daily assuming an increasingly important role in organization affairs. The understanding doctor, if the knowledge he possesses is correctly applied and understood, can be of considerable help to the employee and employer alike. This is dependent upon the complete cooperation of the individual who recognizes something of his trouble and knows to whom to turn for help. The prescription involves the provision of a suitable working environment. From the point of view of management, this entire question is most important in executive development programs.

For several years it has been company policy to invite key personnel to have a complete periodic health inventory. Of the total number invited in 1950, 92% responded; 8% did not—31 persons out of a total of 371.

Of the 340 examined, 105 (31%) were found to have no disease, while 235 (69%) had medical problems which were investigated. These 235 persons represented a total of 277 medical diagnoses, 97 of which could be corrected. Of the 97 correctible disorders, 57% were sufficiently serious to impair the employee's efficiency at work, while the remaining 43% made no difference in working efficiency but did merit correction.

There are many warning signs of poor health or impending disease. It is the physician's job to point out the danger signals. Heeding them will often permit the physician to make an early diagnosis of a condition that can be corrected before it kills, or, if not corrected, materially modified. The important danger signals and what they mean must become more common knowledge.

(The above article is from Industrial Medicine and Surgery, Vol 20, No. 7, July 1951)

W A I T !

Do you know that the following immunizations are required for Army personnel stationed in the United States:

AGENT	NUMBER OF DOSES	INDIVIDUAL DOSE	INTERVAL BETWEEN DOSES	WHEN INDICATED
Smallpox vaccine	1	Contents 1 capillary tube	- - - - -	Every 3 years.
Typhoid- parathyphoid vaccine	3	1st dose, 0.5 cc. 2d dose, 1.0 cc. 3d dose, 1.0 cc.	7 to 28 days	Annually.
Tetanus toxoid (plain)	3	Each dose, 1.0 cc.	Minimum of 21 days.	One year after initial series, and upon occur- rence of wounds or burns as di- rected by the medical officer.

RESTRICTED

ITIAW

RESTRICTED